Good morning. I would first like to thank you all for inviting me here today. I feel honored and greatly appreciate the opportunity to testify on behalf of Veterans and their families. Before I begin I want to introduce myself and the gentleman sitting next to me.

My name is Sydney Willingham Schoellman. I live in Allen Texas with my husband and two children near both my Mother and one of my Sisters who is in attendance today, Sarah Bell. The gentleman sitting next to me is a great friend of the Willingham family named Larry Taylor. Larry is an attorney for the Cochran Firm in Dallas and previously served as both a District Attorney for Dallas County and on another occasion served as the Director of Outreach for Congresswoman Eddie Bernice Johnson. Larry and the Willingham family became dear friends due to our matching principles concerning faith, and our United States Veterans.

I come to you all today on behalf of not only my Dad, deceased Korean War Veteran Gary Willingham but also on behalf of all Veterans and their families. My Dad, Gary Willingham was a vibrant, God fearing patriot who at the age of 80 functioned in life as that of a 65 year old. He lived in his own apartment, drove himself around and even grew and harvested his own vegetables. He was a great man of faith who lived his life based on strong principles. My Dad loved the United States and when not busying himself with different events, you would find him combing news networks so that he could stay up to date with what was going on in our great Nation. He never passed on exercising his right to vote and never missed a birthday party for one of his very young grandchildren. He was the model of what a Dad, Grandfather and citizen should be. He was not a man that took handouts, not even when he struggled to raise 3 daughters on his own. Because he believed in earning everything he got he felt it was only appropriate to rely on the VA Health System for his healthcare needs, he did after all earn it. It was his pride and this belief that made him continue to use the Dallas VA for his healthcare for many years, never complaining. He believed, as my two children would say, “you get what you get and you don’t throw a fit”.

In 2009 he noticed a lump forming in his neck so he went to the Dallas VA to have it examined. A biopsy was done and he was told that it would take surgery to remove it but not to worry, it was benign. I took him to the Dallas VA in 2009 to have that lump removed. At that time we were told that they hadn’t excised the entire tumor but they had no fear that it would cause him problems in the future. Over the next year in check-up after check-up he was told that they believed he had cancer somewhere in his body but that the origin of the cancer could not be located. Over the next year he would be subjected to multiple PET scans and at one point, a tonsillectomy. The guess made by the doctors at the Dallas VA was that the cancer could stem from his tonsils. After an unnecessary tonsillectomy they discovered that they had guessed wrong. By 2010 the lump had returned and the surgeons at the VA again recommended to my Dad that they should operate to remove it. In the morning of November 18, 2010 my sister Sarah, my Dad and I arrived at the Dallas VA at approximately 5:45 in the morning. We checked in to Day Surgery and were sent to wait in the waiting room for approximately thirty minutes or so. After those thirty minutes my Dad was called back to the surgery holding area. Once he had his gown on and was settled my sister and I were allowed to go back and sit with him. After continuous hours of waiting Sarah and I ran down to the canteen to grab a bite to eat. When we returned we were informed that they had taken Dad back to be prepared for surgery.

After a lot of pleading and being pushy we were escorted to the surgery prep waiting room. We spent another few hours there before they finally took my Dad, who had not eaten since the night before back into the OR. We arrived at the Dallas VA at approximately 5:45am and he was not taken back to begin the surgery until 2:25pm. After waiting for over six hours, two surgeons emerged and began telling us about the surgery. During their explanation we were told that multiple tears had been made into his jugular vein which caused a massive blood loss. To stop the blood loss they began clamping everything. The next statement is a direct quote from the surgeon, "we realized six minutes later that we had clamped his carotid artery". To sum our story up, because of the clamping of his carotid artery my Dad suffered a massive stroke. Due to improper tying off of the veins in his neck he would undergo 3 more surgeries to stop the internal hemorrhages that kept forming. His fifth surgery to place a feeding tube would occur a mere three days after the first surgery. My Dad would spend approximately three weeks in ICU and would later spend a week on a patient floor. After the week on the patient floor we were told that he needed to be discharged because per his physician, "had he not suffered a stroke he would have already been discharged". At that time we were also told that due to the tracheotomy in his neck, he could not continue his care at the VA's rehab facility because they were not equipped to handle patients with tracheotomies. We were urged by an employee at the Dallas VA to get our Dad out of that hospital because it was not safe for him. We were also told to obtain his records as quickly as possible before they disappeared. Upon obtaining my Dad's records we found a fact that explained why the employee urged us so strongly to get them. By reading his records we discovered that his carotid artery hadn't been clamped for only 6 minutes. His brain was starved of blood and oxygen for fifteen minutes. Had we been aware of the actual amount of time his carotid artery was clamped, our decisions would have been far different. We used private insurance to place him at a Long Term Acute Care Hospital where he nearly passed away twice. He was then moved to another facility that due to a failed acquisition closed its doors a week after his arrival. He was subsequently moved to a facility where we later determined, using a hidden camera, that he was being abused. All of this, for a Man who stood up for his country? After an impromptu meeting with the Dallas VA Administration room was made available for him in their rehab unit. He spent the next six months or so completely immobile there at the opposite end of a hallway from the nurses' station. Every day his dignity was stripped away as he defecated in a diaper then dug his own feces out because he wasn't being tended to properly. We made several requests that he be moved closer to the nurses' station because of this issue and because of his severe paralysis. Those requests went unanswered though many promises were made. My Dad died on December 24, 2011 due to bacterial sepsis and aspiration pneumonia. E coli, like that found in feces was found in his body and around his heart. He drowned in the tube feedings that were improperly administered. Since his death we have filed a Federal Tort Claim against the VA. In response to our claim we were offered a very small monetary amount and were told, "well, he was 81 and had thyroid cancer". Among the doctors named in our claim was the attending surgeon. We were shocked to find out that he could not be held liable because, contrary to the surgical notes, he was not a Dallas VA employee. As a result the VA is refusing to claim full responsibility for an act committed in their facility.

I am here relaying our graphic, horrific experience so that no other Veteran or their family will experience what we did. In my time working for a large health system in Texas I learned quite a bit. I have been able to take what I learned and apply it to the experience we had and can tell you without any doubt that this system is severely broken.

I feel the key issues that need to be addressed are the following:

1. Accountability
2. Customer Service
3. Risk Management/Family Services
4. Secretary Shinseki

Accountability – There seems to be no accountability at the Dallas VA. It has become apparent to me that surgeons are allowed to operate on our Veterans under the supervision of people who aren't even employees of the VA. This isn't a fact that is communicated to our Veterans before they agree to surgery. You aren't told that the person supervising your surgery is not an employee of the health system and cannot be held accountable through the VA in any claim or complaint. Why are we allowing people not accountable by the health system to supervise or perform operations on our Veterans? Is this a cost saving measure? If so, I can testify that it ends in the Veterans, or families of our Veterans having no ground for retribution. This is a clever, intentionally crafted way for the VA to claim no liability for what is done in their own facilities. In our case the accountability was skirted with a simple statement made by the surgeon herself, "everything I did was done under the supervision of the attending". That statement was all it took for the VA to wash their hands of the situation. This "washing of hands" seems to be a common theme throughout this healthcare system. If you were to step outside of the VA Healthcare System you would see that administrations, physicians and employees are held very accountable. There is no explanation for why a Veterans hospital can have multiple complaints and life threatening or life ending mistakes and still have the same members in administration year after year.

Customer Service – Customer Service and Accountability go hand in hand. At a public health system patients pick and choose what surgeon or doctor to use. That is not the case for our Veterans. The Veterans that enter the VA Health System are what you could call a "captive audience". Their earned healthcare is conducted in a place where customer service is not demanded. For some Veterans, the VA hospital is the only care available to them. Because they must get their care there, they do. These patients are captive within this health system and the employees and administration are well aware of that. Because the VA, unlike public or civilian hospitals, does not have to compete for its business there is no need to institute high expectations where customer service is concerned. These patients are real people, not numbers. Has the human factor been lost amidst the sea of paperwork and financials?

Secretary Shinseki – My last point has to do with Mr. Shinseki and his leadership. In article after article you can read of his inability to properly manage things for our Veterans. From claim back logs, lack of discipline toward his administrators and his propensity to wash his hands of an issue rather than dealing with it, Mr. Shinseki has proven that he does not deserve the responsibility he has been given.

I have seen and read about leaders within our government who, regardless of party affiliation, cannot get Mr. Shinseki to act upon or follow through on issues. Mr. Shinseki is the preverbal brick wall in most of the issues facing our Veterans. Where is his accountability? Why is it, no matter how well publicized an issue is, or how hard a battle is being fought for our Veterans, once it hits his desk it is dead in the water? What steps are being taken to fix this?

I feel fixing these issues is actually pretty simple. I propose that we use an outside agency to conduct Patient Satisfaction surveys with our Veterans. Most public hospitals employ agencies like these and use the results to set minimum performance standards for their hospitals. By implementing these surveys and requiring this accountability you will create an improved environment for our Veterans. It has been well documented that the administrators of the VA have been awarded bonuses with no regard to poor performance. With these surveys in place you are able to tie bonus eligibility and amounts to how the patient, our Veterans feel about the service they are receiving. I feel these surveys would also employ a degree of transparency that this organization hasn't had before. In addition to Patient Satisfaction surveys there needs to be a survey put into play that measures employee engagement as well. If we can improve the environment for the employees, they will provide a better quality of care.

It seems to me and I've concluded, after having many conversations with Veterans, current and past employees that one of the best ways to fix this broken system would be to approach the entire health system the same way a private health system approaches problems. I do not feel this can be done correctly using the internal resources now available to the VA. I implore you, please bring in an outside, objective party to examine these hospitals. Employ the service of a consultant who can create programs that will benefit our Veterans. The best way to fix these problems is to stop doing what has been done and look for other solutions to this ever growing problem.

I want to thank you all for asking me to testify today. I would like to leave you with one last statement and a video clip. On my Dad's deathbed, when he couldn't speak he wrote a note to me that said, "VA murderers…get them Syd". While I'm not "getting" anyone I will spend the rest of my life fighting for these national treasures and their families with the hope that no one will go through or lose what we did.